



NCFLEX FAMILY/EMPLOYMENT STATUS CHANGE FORM

www.ncflex.org

Form must be completed within 30 days from the date of the event. Changes are effective the first of the month following the date of the event, with the exception of birth or adoption. Changes for a birth or adoption may be effective on the date of the event.

SECTION A: EMPLOYEE INFORMATION

Name (Last, First, MI):	Date of Birth:		
Work Phone: ()	Social Security Number:		
Home Address:	City:	State:	Zip Code:
<input type="checkbox"/> Check this box if your name or address has changed	Previous Name:		

SECTION B: TYPE OF FAMILY/EMPLOYMENT STATUS CHANGE (Check one)

I incurred the family/employment status change event on the following date:

<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth or adoption of child (increase election only)	<input type="checkbox"/> Begin/End of spouse's employment	<input type="checkbox"/> Begin unpaid leave of absence (employee or spouse) <input type="checkbox"/> Return from unpaid leave of absence (employee or spouse) <input type="checkbox"/> Significant change in health coverage due to spouse's employment
<input type="checkbox"/> Divorce	<input type="checkbox"/> Legal separation (must be living apart from spouse at least 90 days)	<input type="checkbox"/> Medicare/Medicaid	
<input type="checkbox"/> NC Health Choice for Children	<input type="checkbox"/> Termination of employee's employment or eligibility	<input type="checkbox"/> From full to part-time (less than 20 hrs/week) and vice versa (employee or spouse)	
<input type="checkbox"/> Death of spouse/child	<input type="checkbox"/> Other (explain)	<input type="checkbox"/> Ineligible dependent due to age, marriage or loss of full-time student status	

Benefits Representative to Complete (employment changes that do not require benefit changes):

- ☐ Transfer from agency/university/community college
☐ 9- 10 month contractors

Last pay cycle for deduction: _____ Date employee returns to work: _____ Termination date: _____

SECTION C: DEPENDENT CHANGE (Check all that apply)

Name (First, Last, MI)	List applicable benefits	Gender M F	Date of Birth	Full-Time Student	Handicap
SPOUSE		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
CHILD (1)		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
CHILD (2)		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
CHILD (3)		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
CHILD (4)		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: DENTAL PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

- ☐ New Coverage ☐ Change Coverage Level ☐ Cancel Coverage **Plan Option** ☐ Low Option ☐ High Option

Coverage Level

- ☐ Employee Only ☐ Employee+One Child ☐ Family ☐ Employee + Two or More Children ☐ Employee + Spouse

Benefit Representative to Complete

Date Form Received _____ Payroll Center #(3 digits) _____ Prior Payroll Center #(3 digits) _____
Reviewed By _____ HBR Work Phone _____

SECTION E: VISION CARE PLAN CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage
 ☐ Change Coverage Level
 ☐ Cancel Coverage
 Plan Option
☐ Basic Plan
 ☐ Enhanced Plan
 ☐ Core Wellness Exam (Employee Only Coverage)

Coverage Level

☐ Employee Only
 ☐ Employee+Family

SECTION F: CRITICAL ILLNESS

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage
 ☐ Change Coverage Level
 ☐ Cancel Coverage

Coverage Level

☐ Employee Only
 ☐ Employee+Spouse
 ☐ Employee + Child(ren)
 ☐ Employee+Family

SECTION G: CANCER CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI Forms.

☐ New Coverage
 ☐ Change
 ☐ Cancel Coverage

Plan Option

☐ Low Option
 ☐ High Option
 ☐ Premium Option

Coverage Level

☐ Employee Only
 ☐ Employee+ Family

SECTION H: VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CHANGE

If you're making dependent changes, list them for the appropriate dependent(s) in Section C under "List applicable benefits."

☐ New Coverage
 ☐ Change
 ☐ Cancel Coverage
 Aviation Pilot/Crew Member, after you select your coverage option, check this box: ☐

Plan Option

☐ Plan 1 Employee Only
 ☐ Plan 2 Employee + Family
 Insurance Amount: \$ _____

Beneficiary Full Name	Mailing Address	Relationship to Employee	Date of Birth	Gender M F		% of Benefit
Primary:						
Contingent:						

SECTION I: CORE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFICIARY CHANGE

You may add Core AD&D coverage only if you are re-enrolling upon a return from leave of absence. Changes to your beneficiary can be made at any time.

☐ Re-enrolling from leave
 ☐ Change beneficiary

Beneficiary Full Name	Mailing Address	Relationship to Employee	Date of Birth	Gender M F		% of Benefit
Primary:						
Contingent:						

SECTION J: GROUP TERM LIFE CHANGE

You will need to submit an Evidence of Insurability Form if you are adding or increasing coverage. Visit www.ncflex.org for EOI forms.

☐ New Coverage
 ☐ Change
 ☐ Cancel Coverage

Employee Insurance Amount: \$ _____
 Children's Insurance Amount: ☐ \$5,000
 ☐ \$10,000

Spouse Insurance Amount: \$ _____

Beneficiary Full Name	Mailing Address	Relationship to Employee	Date of Birth	Gender M F		% of Benefit
Primary:						
Contingent:						

SECTION K: FLEXIBLE SPENDING ACCOUNTS (NEW ANNUAL CONTRIBUTION AMOUNT) CHANGE

Health Care FSA (Annual Min. \$120, Annual Max. \$2,500) New Annual Contribution: \$ _____

Dependent Day Care FSA (Annual Min. \$120, Annual Max. \$5,000) New Annual Contribution: \$ _____

Your New Annual Contribution should equal the total amount you would like to contribute to the FSA(s) of 12/31 of the current plan year. Per pay contributions equal: new annual contribution minus total year-to-date contributions divided by the pay periods remaining for the year.

☐ Cancel Health Care FSA
 ☐ Cancel Dependent Day Care FSA
 ☐ Cancel NCFlex Convenience Card

This is to certify that on the family/employment status change event date in Section B, I incurred the family/employment status change(s) checked in Section B, and wish to change my plan benefits as indicated on this form. I understand that the change must be consistent with the family/employment status change event and requested within 30 days of the event, and I might be required to provide documentation to my benefits representative. I further understand that if my costs/contributions need to be caught up, they may be deducted from a future paycheck. Note: The IRS provides guidelines for the above family status changes and requires that you maintain legal documentation of the changes in your personal records. Examples of documentation include marriage, birth or death certificates; divorce decrees; notice of legal separation; proof of change in spouse's employment; or, adoption papers.

Employee Signature: _____

Date: _____